



# URGENT PRODUCT REQUEST FORM: ABBOTT METABOLIC FORMULAS & SIMILAC® PM 60/40\*

- Please fax both this form and physician order to **1-877-293-9145** or email to **metabolicorders@abbott.com**
- Physician order should include: patient name, date of birth, product name, amount of product per day or month, duration of product use requested, doctor name, contact phone number, DEA or NPI number, and physician signature

Patient Name: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

- Product:
- |   |  |   |                                      |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Calcilo XD®          | <input type="checkbox"/> Cyclinex®-1       | <input type="checkbox"/> Cyclinex®-2        | <input type="checkbox"/> Glutarex®-1 |
| <input type="checkbox"/> Glutarex®-2          | <input type="checkbox"/> Hominex®-1        | <input type="checkbox"/> Hominex®-2         | <input type="checkbox"/> I-Valex®-1  |
| <input type="checkbox"/> I-Valex®-2           | <input type="checkbox"/> Ketonex®-1        | <input type="checkbox"/> Ketonex®-2         | <input type="checkbox"/> Phenex®-1   |
| <input type="checkbox"/> Phenex®-2 Unflavored | <input type="checkbox"/> Phenex®-2 Vanilla | <input type="checkbox"/> Pro-Phree®         | <input type="checkbox"/> Propimex®-1 |
| <input type="checkbox"/> Propimex®-2          | <input type="checkbox"/> ProViMin®         | <input type="checkbox"/> Similac® PM 60/40* | <input type="checkbox"/> Tyrex®-1    |
| <input type="checkbox"/> Tyrex®-2             |  |   |                                      |

Amount Needed (*only these options*):  **1 case** *or*  **2 cases** (1 case = 6 cans)

Shipping Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Shipping Address Type:  **Patient Home** *or*  **Hospital**

\* *For hospitals ordering Similac PM 60/40 for an urgent patient need, please order directly from Abbott as a standalone order (item #00850), in addition to submitting this form.*

Metabolic Center/Hospital Name: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Metabolic RD or Other HCP Name (*if applicable*): \_\_\_\_\_

Physician or Office Phone Number: \_\_\_\_\_

Physician or Office Email: \_\_\_\_\_

Healthcare Professional Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Healthcare Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**By checking this box, you attest that the patient need has been determined urgent by a physician.**

*If a patient needs additional product, please re-submit this form. For patients being discharged from the hospital with an urgent need for these products at home, healthcare professionals should submit this form along with a physician order.*

By submitting this form and your patient's information, you represent and warrant that you've obtained any necessary consents or authorizations from your patient to disclose their information to Abbott Nutrition and its contracted third parties.